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Let's get the Conversation Started

Helen Meehan - Lead Nurse Palliative and End of Life Care

Conversation Project

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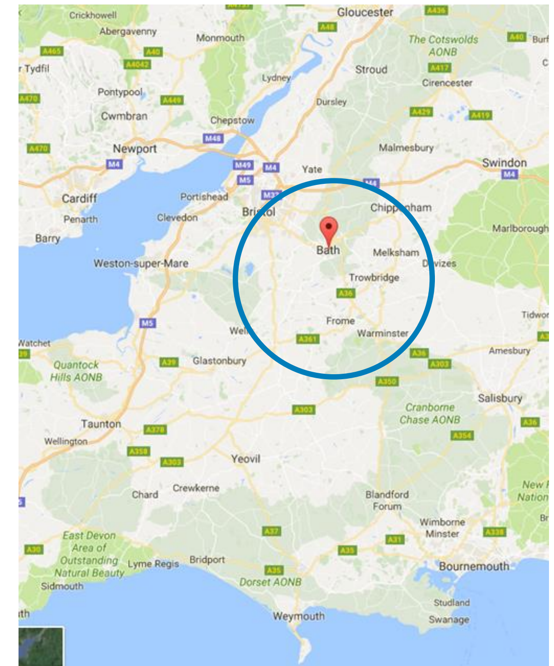
Background

- Royal United Hospitals (RUH) – catchment population of 500,000 with 565 acute beds
- Serves 4 CCGs
- End of Life Care Steering Group
- Integrated specialist palliative care and end of life care (EOLC) team



End of life care

Outstanding

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Why focus on conversations?

- 78% of people that die have **at least one admission to hospital** in their last year of life[1]
- A third of all hospital admissions in last year of life **occur in the last 30 days before death[1]**
- Although deaths in hospital nationally have reduced, **most people still die in hospital** (1436 deaths in the RUH in 2015/16)
- People who have engaged in Advance Care Planning (ACP) are **less likely to die in hospital[2]**

1. National end of life care Intelligence May 2012
2. National Council for Palliative Care 2015

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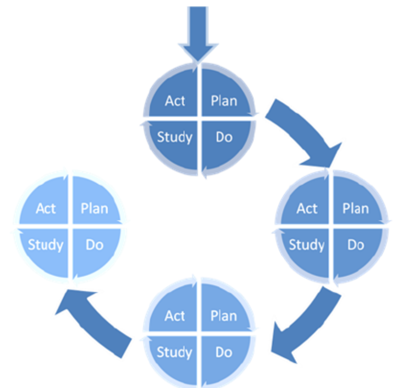
Conversation Project – aims

- **Earlier recognition** of end of life (EOLC) or recovery uncertain in acute hospital setting, including frail elderly patients and patients with dementia
- **Improving communication** and advance care planning for these patients and their families
- Better awareness of the need to **improve documentation** of conversations related to end of life care to inform management plans
- **Improve sharing of information** related to ACP on transfer and discharge of these patients



The King's Fund
The Health Foundation
CQUINS Commissioning for Quality and Innovation
NHS Health Education South West

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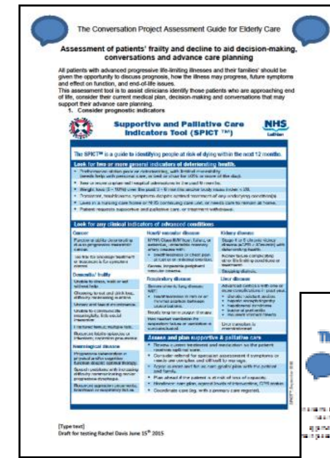
What did we do?

- Let's get talking – with patients, families, Trust members and staff
- Adopted SPICT[3] and Rockwood Frailty[4] assessment tools to support identification of patients with EOLC and frailty
- Conversation Key Card for staff, ACP information leaflet and piloting ACP template for frailty
- Ward based training, induction training and eLearning module for end of life care which includes principles of the Conversation Project
- Intranet resource for the Conversation Project and ACP

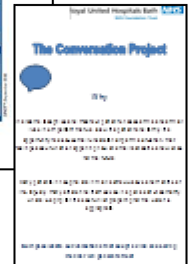

The Conversation Project Assessment Guide for Elderly Care

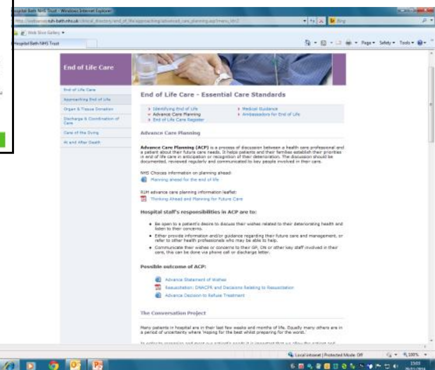
Assessment of patients' frailty and decline to aid decision-making, conversations and advance care planning

All patients with advanced progressive life-limiting illnesses and their families' should be given the opportunity to discuss prognosis, how the illness may progress, future symptoms and effect on function, and end-of-life issues.
This assessment tool is to assist clinicians identify those patients who are approaching end of life, consider their current medical plan, decision-making and conversations that may support their advance care planning.

1. **Consider prognostic indicators**

Supportive and Palliative Care Indicators Tool (SPICT ™)





www.spict.org.uk[3]
Rockwood et al CMAJ 2005[4]

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Conversation Project Key Card – let's CHAT

Consider: assessment of frailty, prognostic indicators, what the patient and MDT tell us

Have conversations: listen to the patient and ask *'what matters most to you,'* have conversations with those important to the patient *'hoping for the best whilst preparing for the worst,'* acknowledge uncertainty of recovery/future

Advise the MDT: does the ward team know and understand the patient's wishes, document conversations and what is important to the patient and the family

Transfer of information: telephone the GP, DN or care home manager, ensure discharge documentation includes summary of discussions had, decisions made and advice about ACP to support ongoing care

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What did we find?

- 50 sets of patient notes audited through quarter 2-4 in 2015/16

- 64% (n32) had problems associated with dementia and frailty
- 78% (n39) admitted to hospital from home and 20% (n10) from a care home
- **46% (n23) patients lacked capacity to be involved in ACP discussions**
- **94% (n47) evidence of discussion with the patient's family/carer**
- 1 patient had a Lasting Power of Attorney for Health and Welfare

- **None of the patients had a community ACP or ADRT on admission**
- None of the patients had a 'This is Me' document on admission

- 46% (n23) of the patients died during admission
- **54% (n27) of the patients were discharged**

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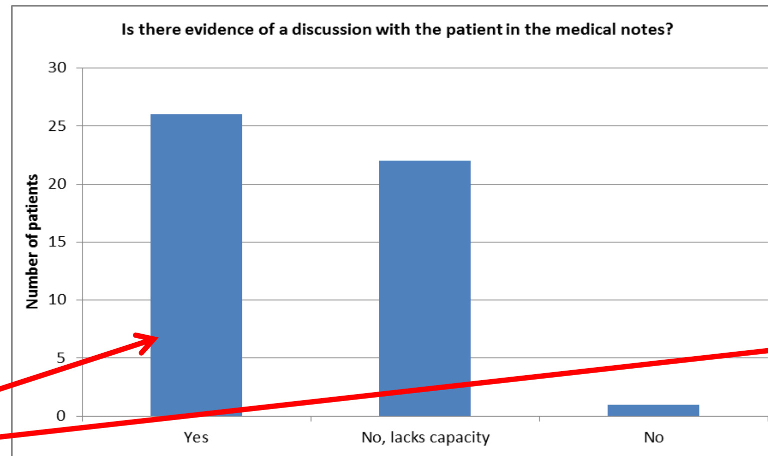
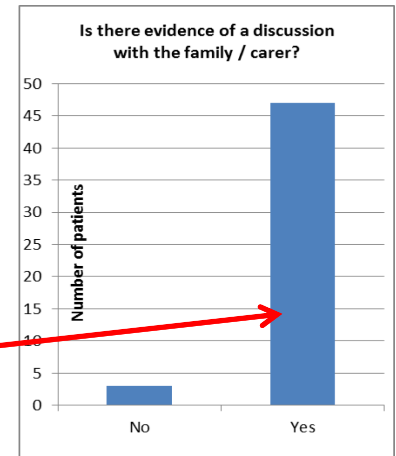
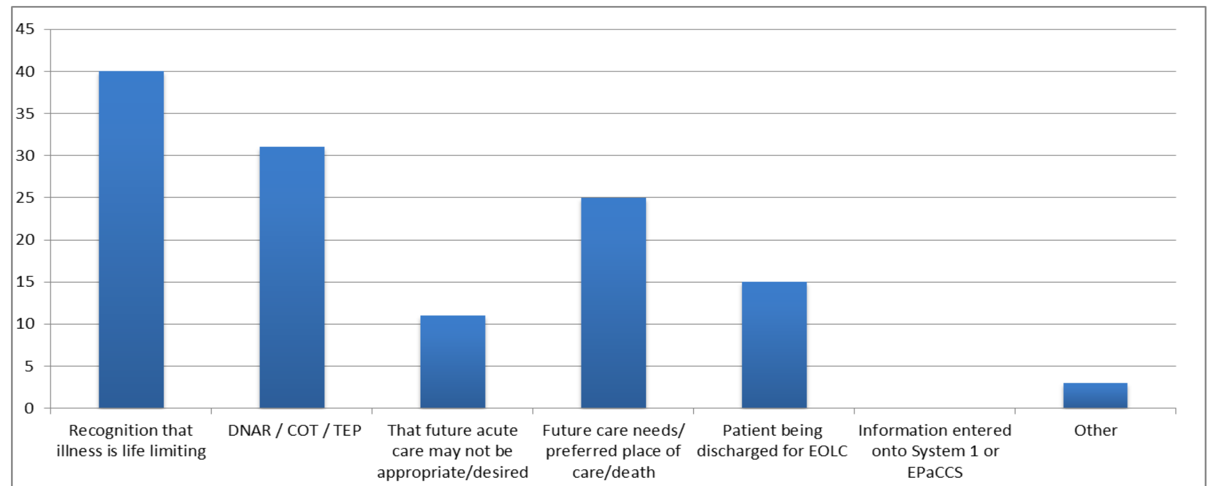
Evidence of conversations in MDT records

- Evidence of discussions with the patient and/or recorded reasons why not appropriate, and discussions with those important to the patient





- Evidence of content of the discussions main themes:
  - Recognition – uncertainty/EOLC
  - TEP
  - Future wishes



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Outcomes from national EOLC audit

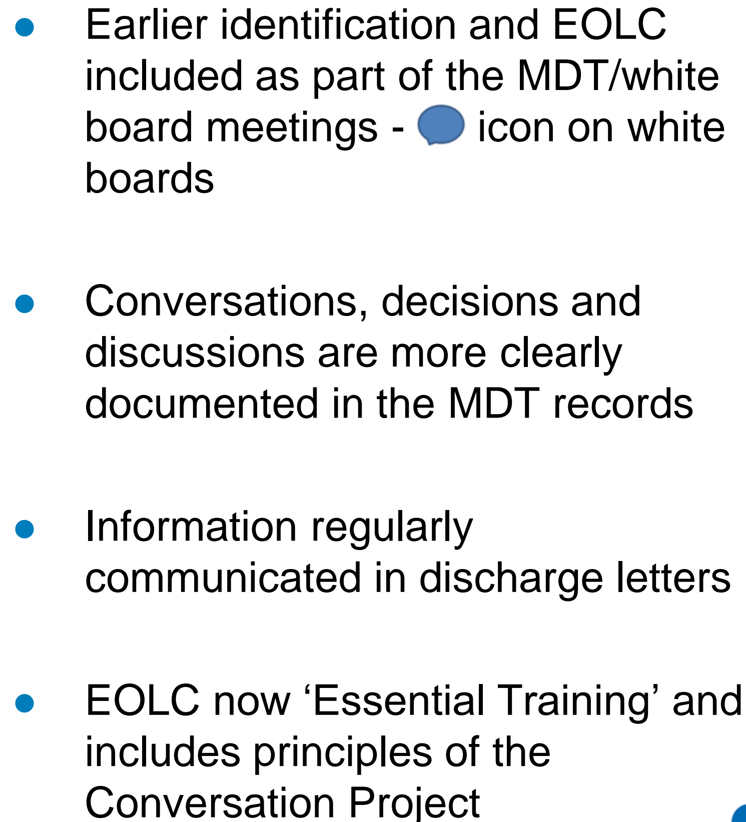
Clinical outcome indicators from the National EOLC Audit – dying in hospital 2015/16

- Evidence of improved communication/ discussions relating to EOLC
- Clinical indicators for communication above national average

	CLINICAL AUDIT	National result	Your site
	Cases in clinical audit	9302	80
	CLINICAL AUDIT INDICATOR	% OF CASES	% of YOUR cases
1	Is there documented evidence within the last episode of care that it was recognised that the patient would probably die in the coming hours or days? **%YES**	83%	81%
2	Is there documented evidence within the last episode of care that health professional recognition that the patient would probably die in the coming hours or days (imminent death) had been discussed with a nominated person(s) important to the patient? **%YES**	79%	81%
3	Is there documented evidence that the patient was given an opportunity to have Concerns listened to? **%YES or NO BUT**	84%	94%
4	Is there documented evidence that the needs of the person(s) important to the patient were asked about? **%YES or NO BUT**	56%	78%
5	Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care? **%YES**	66%	86%
		National	

End of Life Care Audit – Dying in Hospital
National report for England 2016

Achievements and challenges



Achievements

- Earlier identification and EOLC included as part of the MDT/white board meetings - icon on white boards
- Conversations, decisions and discussions are more clearly documented in the MDT records
- Information regularly communicated in discharge letters
- EOLC now 'Essential Training' and includes principles of the Conversation Project

Challenges

- Maintaining a cultural change of earlier recognition of EOLC needs and talking earlier
- Maintaining staff engagement and motivation to include this in their daily work
- To support staff in identifying cues and engaging in what can be difficult and challenging conversations
- To seek ongoing feedback from patients and families and use this to inform future practice

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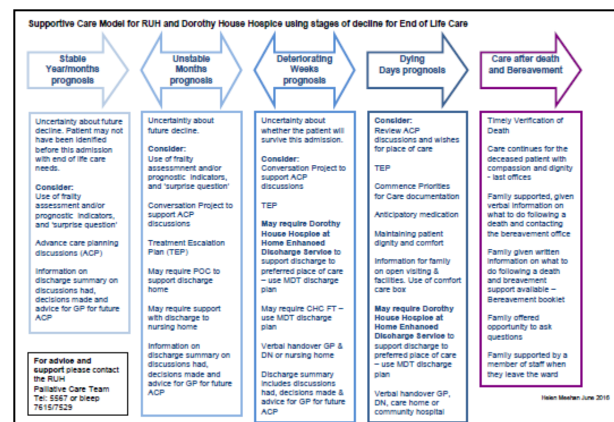
Future work and next steps

- Conversation Project on trust electronic patient record – March 2017
- To explore how the ACP discussions and decisions had in hospital impact on care after the patient is discharged
- The Health Foundation – grant to support extension of the Conversation Project with community partners
- Supportive care model including Conversation Project principles
- Supporting rapid discharge to preferred place of care pathway and 'Enhanced Discharge Service'
- 'See it My Way' event for EOLC 12th May 2017 – sharing patient stories



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